Reply to: comparing C-MAC videolaryngoscope with direct laryngoscopy for emergency intubation

Ruetzler, Kurt ; Sulser, Simon ; Ubmann, Dirk ; Spahn, Donat R

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Kurt Ruetzler, Simon Sulser, Dirk Ubmann and Donat R. Spahn

From the Institute of Anaesthesiology (KR, SS, DU, DRS), University Hospital Zürich, Zürich, Switzerland and Departments of Outcomes Research and General Anesthesiology, Cleveland Clinic, Cleveland, Ohio, USA (KR)

Correspondence to Kurt Ruetzler, MD, Departments of Outcomes Research and General Anesthesiology, Cleveland Clinic, 9500 Euclid Avenue, Cleveland, OH 44195, USA
Tel: +1 216 407 4108, fax: +1 216 444 2294; e-mail: kurt.ruetzler@reflex.at

Editor,

We appreciate the interest of Liu *et al.*[1] in our publication[2]. We would like to comment on the questions raised in their letter.[1]

First, all three anaesthetists were properly trained in both techniques (C-MAC videolaryngoscope and direct laryngoscopy, University Hospital Zurich, Zurich, Switzerland) prior to the start of this study. Of course, all three had much greater experience with direct laryngoscopy (average about 1000 intubations) compared with C-MAC (between 30 and 300 intubations), but their level of training was sufficient. The sufficient level of training was confirmed by the finding of our study that the success rate at the first intubation attempt was 100 and 98%, respectively. Second, we basically agree that switching the intubation technique from video to direct laryngoscopy might be an important advantage of several videolaryngoscopes. However, this was neither investigated, nor indicated, in any intubation attempt to achieve successful intubation in our study. Although the clinical assessment of Liu *et al.* may be right, scientific evidence for their conclusion is incomplete. Third, at our institution, a stylet is mandatorily used for all rapid sequence intubation procedures. Therefore, all (endotracheal tubes) in both groups were prepared with a hockey-stick shaped stylet in advance.[3] Fourth, we agree with Liu *et al.* that a cut-off time might be important in some airway studies. However, in the clinical and especially the emergency setting, clinical judgement and decision-making is more important than any definition of time-frame. In general, the rate of successful endotracheal intubation and avoidance of unrecognised oesophageal intubation are clinically of the highest importance. In contrast, the clinical impact of time to intubation is questionable as a difference of a couple of seconds is usually of no clinical relevance. Finally, the well tolerated use of the videolaryngoscope is completely supported by the data of our study and we, therefore, basically agree that the use of the videolaryngoscope might be an acceptable first-line intubation device. However, any recommendation for the first-line device during emergency airway management should be based on the provider's experience and the availability of the device.

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